COVERED CALIFORNIA

August 20, 2013

Gary Cohen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Approval of Bridge Program Demonstration Project

Dear Mr. Cohen, Gary

I am writing to request approval of Covered California's proposal to establish a three-year Bridge Program Demonstration Project. This proposal provides a strategy that builds on federal guidance and promotes the twin goals of affordability and continuity of care.

Offering affordable health plans is a critical priority for Covered California and ensuring high enrollment of low-income Californians cannot be done without it. Covered California is requesting federal approval for a three-year Demonstration Project to test the effectiveness of a strategy using Bridge plans to achieve the following objectives: promote continuity of coverage, reduce the disruptions in continuity of care associated with changes in health plans, and create access to more affordable coverage. The Bridge plan approach offers the potential of significant, measureable benefits for its eligible enrollees.

Our proposal has been endorsed by the Covered California Board. Legislation authorizing the Bridge program was enacted on July 11, 2013.

Covered California proposes a three-year Demonstration Project to test the effectiveness of Bridge plans. Under this proposal and to the extent approved by the appropriate federal agency, Covered California would contract with Medi-Cal Managed Care Plans who wish to participate in the Bridge Program to offer qualified health plans to provide coverage for three Exchange-eligible target populations with incomes under 250 percent of the Federal Poverty Level:

- New Covered California enrollees who were previously enrolled in Medi-Cal Managed Care Plans who participate in the program;

- Family members eligible for coverage in Covered California who have other members of the same MAGI household enrolled in Medi-Cal Managed Care Plans participating in the program; and
- Parent or caretaker relative of a Medi-Cal enrolled child.

The proposed Demonstration Project would expire in 2017, and would be evaluated to determine its effectiveness. Based on this evaluation, the state could consider applying for a five-year state innovation waiver as allowed under the Affordable Care Act.

Our proposal, which is more fully described in the attached policy brief, addresses the specific issues that were outlined in the CMS guidance on Bridge Programs. In addition, we are attaching the law authorizing the Bridge Program in California, and our enrollment projections from the U.C. Berkeley Center for Labor Research and Education.

Thank you for considering our proposal and we welcome the opportunity to work together with you and your staff to address any policy or implementation concerns.

Sincerely,

Peter V. Lee
Executive Director

Attachments

Bridge Plan Demonstration Project: A Strategy to Promote Continuity of Care & Affordability

SUMMARY

Offering affordable health plans is a critical priority for Covered California and ensuring high enrollment of low-income Californians cannot be done without it. Covered California is requesting federal approval for a three-year Demonstration Project to test the effectiveness of a strategy using Bridge plans to achieve the following objectives: promote continuity of coverage, reduce the disruptions in continuity of care associated with changes in health plans, and create access to more affordable coverage. The Bridge plan approach offers the potential of significant, measureable benefits for its eligible enrollees.

The Covered California Board adopted the Bridge plan policy on February 26, 2013, and directed staff to seek federal approval for the proposal. Governor Brown's 2013-14 budget proposed the Bridge concept. The Legislature passed SBx1 3 (Hernandez) and the Governor signed it on July 11, 2013.

Proposed Demonstration Project. Covered California proposes a three-year Demonstration Project to test the effectiveness of Bridge plans. Under this proposal and to the extent approved by the appropriate federal agency, Covered California would contract with Medi-Cal Managed Care Plans who wish to participate in the Bridge Program to offer qualified health plans to provide coverage for three Exchange-eligible target populations with incomes under 250 percent of the Federal Poverty Level (FPL):

- New Covered California enrollees who were previously enrolled in Medi-Cal Managed Care Plans who participate in the program;
- Family members eligible for coverage in Covered California who have other members of the same MAGI household enrolled in Medi-Cal Managed Care Plans participating in the program; and
- Parent or caretaker relative of a Medi-Cal enrolled child.

The proposed Demonstration Project would expire in 2017, and would be evaluated to determine its effectiveness. Based on this evaluation, the state could consider applying for a five-year state innovation waiver as allowed under the Affordable Care Act.

BACKGROUND

For low-income Californians, the monthly premium cost for health coverage will be a significant factor in determining whether they will enroll in a plan. Federal subsidies – based on household income – will significantly reduce premiums and out-of-pocket costs. Table 1 illustrates how these federal tax credits impact monthly premiums for a hypothetical 40-year-old policyholder. In addition to premium subsidies, cost-sharing reductions available to enrollees in Silver-level plans will reduce point-of-service costs

for individuals with incomes between 100 and 250 percent of the FPL. These federal subsidies significantly reduce out-of-pocket expenditures, such as deductibles, co-pays, and co-insurance for individuals in this income range. Together these subsidies help to ensure that both coverage and the cost of accessing care remain affordable for lower income Californians thereby encouraging initial enrollment and retention of coverage.

While affordable coverage is available for a range of incomes, coverage is provided through two programmatic structures – Medi-Cal and Covered California – offering different sets of plans throughout the state. When a family's circumstances change, the family members often move between these programs. Offering options that allow for the continuity of care from their existing providers is an important value.

Several studies have attempted to quantify the magnitude of movement that can be expected to occur once reforms in 2014 are in place. The most frequent cause of this change, sometimes called "churn," is change of income. Churning can result in individuals changing health plans and having to seek care through different provider networks. This creates risks for enrollees, particularly those who are under active care for chronic conditions.

Using CalSIMS and adjusted Survey of Income and Program Participation (SIPP) data to represent the Medi-Cal enrollee population, the UC Berkeley Center for Labor Studies found that of approximately 15.1 percent of Medi-Cal enrollees who leave Medi-Cal over 12 months due to income increases above 138 percent of the FPL, 13.7 percent would be eligible for participation in Covered California and receipt of an Advanced Premium Tax Credit. (This excludes an estimated 9 percent who obtain employer-sponsored coverage.) (See Table 2.)

Having different sources of coverage for different family members can be another cause of confusion for families. This is a concern for families with household incomes between 138 and 250 percent of the FPL whose children are enrolled in Medi-Cal/CHIP while the parents are enrolled in Covered California health plans. These families would benefit by having the option of enrolling all family members in the same health plan to help simplify their consumer health care experience.

Medi-Cal Managed Care plans offer an important opportunity to address both provider-level continuity and affordability. Today, almost 5 million Medi-Cal beneficiaries in 30 counties receive their health care through these Managed Care plans. This number will grow due to the transition of the Healthy Families Program to Medi-Cal, and the Medi-Cal eligibility expansion of childless adults, many of whom are now enrolling in the county-based Low-income Health Program (LIHP), and the extension of managed care to the remaining 18 counties. By encouraging Medi-Cal Managed Care plans to participate in Covered California, continuity of care can be promoted by giving low-income consumers the option of staying in their same health plan even though their eligibility may shift between Medi-Cal and Covered California.

Medi-Cal Managed Care plans, particularly in the larger counties where Local Initiatives operate, provide added support to the safety net service that will be an ongoing need, despite reductions in the number of uninsured. In a November 2012 analysis, the UC Berkeley Center for Labor Research and Education projected over 3.1 million Californians would remain uninsured by 2019, even assuming the Exchange has enhanced enrollment model. These uninsured individuals will continue to rely on a robust safety net for their health care needs. Medi-Cal Managed Care plans play an essential role in supporting the local health care safety net, which is often the provider of last resort for those without health insurance. By providing these plans with opportunities to participate in Covered California, they can continue to provide support for the safety net service infrastructure.

In responding to interest in other states in encouraging continuity of coverage and care, the Centers for Medicare & Medicaid Services recently commented on "Medicaid Bridge Plans" in its December 10, 2012, Frequently Asked Questions (FAQ). The CMS response described the potential for a state-based Exchange to certify a Medicaid Managed Care plan as a Bridge Qualified Health Plans in state exchanges. Such a plan "would allow individuals transitioning from Medicaid or CHIP coverage to the Exchange to stay with the same issuer and provider network, and for family members to be covered by a single issuer with the same provider network." This approach, CMS said, is intended to promote continuity of coverage between Medicaid or CHIP and the Exchange. The FAQ outlined several requirements for Bridge plan proposals:

- *The state must ensure that the health insurance issuer complies with applicable laws, and in particular with Section 2702 of the Public Health Service Act.*
- *The Exchange must ensure that a bridge plan offered by a Medicaid managed care organization meets the qualified health plan certification requirements, and that having the Medicaid managed care organization offer the bridge plan is in the interest of consumers.*
- *As part of considering whether to certify a bridge plan as a qualified health plan, the Exchange must ensure that bridge plan eligible individuals are not disadvantaged in terms of the buying power of their advance payments of premium tax credits.*
- *The Exchange must accurately identify bridge plan eligible consumers, and convey to the consumer his or her qualified health plan coverage options.*
- *The Exchange must provide information on bridge plan eligible individuals to the federal government, as it will for any other individuals who are eligible for qualified health plans on the Exchange, to support the administration of advance payments of premium tax credits.*

In his 2013-14 budget, Governor Brown proposed to implement a program based on the federal Bridge option. The Brown Administration sponsored the legislation to authorize the Bridge program -- Senate Billx1 3 (Hernandez) -- which was passed by the Legislature and signed into law on July 11, 2013.

PROPOSAL FOR CONSIDERATION

Bridge Plan Strategy to Promote Continuity of Coverage and Affordability

Covered California proposes to implement a three-year Demonstration Project to test the effectiveness of the Bridge plan approach. Under this proposal and to the extent approved by the appropriate federal agency, Covered California would contract with Medi-Cal Managed Care Plans who wish to participate in the Bridge Program to offer qualified health plans to provide coverage for three Exchange-eligible target populations with incomes under 250 percent of FPL:

- New Covered California enrollees who were previously enrolled in Medi-Cal Managed Care Plans who participate in the program;
- Family members eligible for coverage in Covered California who have other members of the same MAGI household enrolled in Medi-Cal Managed Care Plans participating in the program; and
- Parent or caretaker relative of a Medi-Cal enrolled child.

Specifically, the Department of Health Care Services (DHCS) would amend its contracts with Medi-Cal Managed Care plans who wish to participate in the Bridge Program to establish a pre-existing obligation to serve Exchange-eligible individuals up to 250 percent of the FPL who qualify for Bridge coverage. The amended contract would require the Bridge plan to accept enrollment of any potentially eligible member. To the extent that bridge plans are determined to be at capacity, Bridge plans would not be able to accept any other individuals.

Covered California would contract with Medi-Cal Managed Care plans to offer Bridge plans that meet the requirements for qualified health plan certification. The monthly premiums charged by Bridge plans would be negotiated between Covered California and the participating Medi-Cal Managed Care plans. These rates would provide enrollees low monthly premiums once the Advance Premium Tax Credit is taken into account.

Bridge plans would allow individuals transitioning from Medi-Cal or Medi-Cal/CHIP coverage to Covered California to stay with the same issuer and thereby retain access to their existing provider network. It would also allow family members of Medi-Cal enrollees and parents or caretaker relatives of a Medi-Cal enrolled child to be covered by the same issuer as the children to simplify their processes for obtaining care. These Bridge plans could offer premiums that would result in very low out-of-pocket premiums for transitioning enrollees. The estimated potential participation in Bridge plans, based on the UC Berkeley Center for Labor Research and Education estimates, ranges from 670,000 and 840,000 in first year.[i]

[i] Estimate is based on CalSIM data and assumes participation of all Medi-Cal Managed Care plans. An estimated 860,000 -1,080,000 are projected to be eligible in the first full year the program is in operation.

Once approval for the demonstration is obtained, an implementation effort will be required to modify our enrollment system to support these new enrollment options, to review and certify Medi-Cal manage care plans to participate, and to negotiate rates. Covered California will develop an implementation timeline in consultation with the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) development team, Covered California staff, and stakeholders.

To foster maximum participation of Medi-Cal Managed Care plans and their Bridge plans, the qualified health plan certification process would be streamlined.

Covered California would conduct an evaluation of the Demonstration Project to determine the extent to which the Bridge Program successfully achieved its objectives of:

- Greater enrollment;
- Promotion of continuity of coverage;
- Reduction in enrollment churn between Medi-Cal and Covered California;
- Greater affordability; and
- Improved health outcomes.

The evaluation would be completed prior to the end of the proposed Demonstration Project in 2017. Based on this evaluation, the state could consider applying for a five-year state innovation waiver as allowed under the Affordable Care Act.

Bridge Plan Demonstration Project: Implementation Issues

Affordability. Offering more affordable coverage products is a key objective of the Bridge plan demonstration project. To maximize enrollment, Bridge plans would have a strong incentive to offer an attractive plan option with a very low premium. Based on an analysis by Milliman, this level of affordability and quality coverage is achievable if the Bridge plan is designated as the lowest Silver-level benefit plan option. To achieve this lower premium level, Covered California would negotiate contracts with existing Medi-Cal Managed Care plans who wish to participate in the Bridge Program to provide coverage for the target population. At this level, the Bridge plan would effectively become an affordable plan option and would encourage the enrollment of individuals who transition from Medi-Cal Managed Care plans to the exchange because of an increase in income. Further, the Bridge plan would offer an affordable choice to other eligible members of a MAGI household with members enrolled in Medi-Cal Managed Care plans, and parents or caregiver relatives of Medi-Cal enrolled children.

Covered California recognizes the Bridge plan design may reduce an eligible individual's federal tax credit and purchasing power for those who prefer to purchase a non-Bridge plan. This is a direct result when Bridge plans offer the lowest Silver-level tier product, thereby shifting downward the federal subsidy relative to the lowest Silver-level tier product that would exist *in the absence* of a Bridge product. The potential

reduction of premium subsidies for those eligible for Bridge plan enrollment is an issue of concern and was discussed by the Covered California Board and by the Legislature during its consideration of the authorizing legislation. Without a change in the foundational structure of Bridge plan pricing as it relates to the federal subsidy calculation, there does not appear to be an alternative mechanism that would avoid the consequence of a reduced premium subsidy. Any potential reduction in premium subsidies would affect only those eligible for the Bridge plan. There would be no impact to enrollees ineligible for Bridge plans, nor would there be any impact to Bridge-eligible enrollees who were not offered a Bridge plan.

To ensure that Bridge plan eligible individuals' purchasing power would be minimally affected, recent state legislation authorizing the Bridge program specified a methodology for Medi-Cal Managed Care plans offering a Bridge product. Senate Bill x1 3 provides that the Medi-Cal Managed Care plans would only be allowed to offer a Bridge product if the premium contribution amount in the Silver category for the eligible individual is either equal to, or less than, the premium contribution amount for the lowest cost Silver plan that would have been available to the individual without the Bridge plan product. By ensuring consumers maintain the same or lower premium contribution amount, the Bridge plan would offer an affordable alternative for enrollees who would be transitioning from Medi-Cal to Covered California, or who would like to enroll in the same plan as their family member enrolled in Medi-Cal. The methodology would allow Medi-Cal Managed Care plans choosing to offer a Bridge plan product two pricing options.

- **Option 1: Price Equal to Lowest Silver.** Medi-Cal Managed Care plans would be able to offer a Bridge plan product that is exactly equal to the premium rate of the lowest cost Silver plan (offered without the Bridge plan), ensuring the eligible individual's premium contribution amount remains the same as they would have paid if the Bridge plan had not been offered.
- **Option 2: Price Lower Than Lowest Silver.** Medi-Cal Managed Care plans would be able to offer a Bridge plan that is less than the lowest cost Silver plan (offered without the Bridge plan). However, to ensure an eligible individual's premium contribution remains equal to, or less than, what it would have been without the Bridge plan, the Bridge plan would have to be offered at the same or greater dollar amount below the lowest cost Silver plan as that lowest Silver plan was offered below the second lowest cost Silver plan.

For example, if a Bridge plan were offered in the Los Angeles Region 15, the second lowest cost Silver plan for a 40-year old enrollee would be $252 per month and the lowest cost Silver plan would be $222, or $30 less. Following the methodology prescribed under SBx1 3, Medi-Cal Managed Care plans in Los Angeles would be able to offer a Bridge plan for a premium rate equal to the lowest cost Silver plan at $222, or for less than the lowest cost Silver level plan. If the Los Angeles Medi-Cal Managed Care plan opted to offer the Bridge plan for less than the lowest cost Silver plan, the Bridge plan would need to be offered for at least $30 less, that is, for $192 or less. Offering the Bridge plan for at least $30 less than the lowest cost Silver plan would

maintain or lower the individual's premium contribution rate from what it would have been without the Bridge plan.

Los Angeles Region 15 Plan Rates	Option 1	Option 2
Second Lowest Cost Silver Plan	$252	$252
Lowest Cost Silver Plan	$222	$222
Bridge Plan	**$222**	**$192 or less**

Attachment 1 shows the proposed rates for 2014 in the 19 rating regions in California. The rates shown are for the lowest and second lowest Silver plans in each region.

In advancing the Bridge Plan Demonstration Project, Covered California acknowledges the benefits of the policy tradeoff. On balance, the Covered California Board and other California policymakers believe the potential benefits of offering Bridge plans, coupled with the requirements under SBx1 3 and our active purchasing authority, outweighs the disadvantages that may result from this policy. The Demonstration Project can provide Covered California with the data to quantify and measure these tradeoffs.

Participation Requirements. Participation by Medi-Cal Managed Care plans in the Bridge program would be limited to plans that comply with the following requirements:

- Bridge plans must agree to amend their contracts with Department of Health Care Services to include a provision to require the plan to cover any applicant who is eligible to participate in Bridge coverage. The three Exchange-eligible target populations with incomes under 250 percent of FPL would include: (1) new Covered California enrollees who were previously enrolled in Medi-Cal Managed Care Plans who participate in the program; (2) family members of the same MAGI household eligible for coverage in Covered California whose families include enrollees in Medi-Cal Managed Care Plans participating in the program; and (3) parent or caretaker relative of a Medi-Cal enrolled child.
- The plan must be certified by Covered California as a Bridge qualified health plan, meeting other certification requirements, and establish a rate structure for Bridge plan enrollees.
- The plan must comply with a medical loss ratio of 85 percent.
- The plan must demonstrate the Bridge plan has a substantially similar provider network as the Medi-Cal Managed Care plans offered by the health plan issuer.

Consumer Choice and Protection. Bridge plan eligible consumers would be able to choose any plan offered through Covered California. However, to facilitate continuity and coverage, individuals transitioning from Medi-Cal Managed Care plans to the exchange would be encouraged, but not required to enroll in the health care service plan or health insurer through which the individual was previously enrolled with – their offered Bridge plan. Similarly, individuals eligible for the Bridge program due to other members of their MAGI household enrolled in Medi-Cal Managed Care plans, would be

encouraged to enroll in the same health care service plan or health insurer as their family member – their offered Bridge plan. Contingent on federal approval, eligible individuals would also have the option to enroll in a different Bridge plan if their primary care provider is included in the contracted network of the other Bridge plan and the eligible Bridge plan is either not offered in the service area or is not offered as a Bridge plan by the Exchange.

The Bridge plan option – offering both low premiums and continuity of care – would provide tangible benefits that advantage Bridge plan eligible enrollees. However, it is acknowledged that these Bridge plan benefits reflect a policy tradeoff. As has been previously noted, non-Bridge plan options would be more costly to the consumer due to the reduced federal subsidy associated with the downshifting of the lowest Silver-level plan rate. The extent of the potential benefits as compared to the reduced subsidy would be a critical component of the Demonstration Project's evaluation.

Eligibility. To the extent approved by the appropriate federal agency, the Exchange would make the Bridge Plan products available to specified populations under 250 percent of the FPL. Consistent with current federal guidance and subject to amended Medi-Cal Managed Care plan contracts, the Bridge plan eligible populations would include:

- New Covered California enrollees who were previously enrolled in Medi-Cal Managed Care Plans who participate in the program;
- Family members eligible for coverage in Covered California who have other members of the same MAGI household enrolled in Medi-Cal Managed Care Plans participating in the program; and
- Parent or caretaker relative of a Medi-Cal enrolled child. However, pursuant to SBx1 3, Covered California has the option to delay to January 1, 2015, this eligible population until it has the operational capability to implement it.

The California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) will provide the on-line portal for completion of the single streamlined application and enrollment in qualified health plans for those eligible for the Advanced Premium Tax Credit. It will also provide the mechanism for enrolling in Bridge plans. Individuals who lose Medi-Cal coverage commencing January 1, 2014, would be eligible for four months of transitional Medi-Cal coverage. Eligible individuals would be able to enroll during the special enrollment period because of their new eligibility status. In subsequent open enrollment periods, a Bridge plan could enroll Exchange-eligible individuals who could demonstrate that their Medi-Cal or Medi-Cal/CHIP coverage was terminated based on income within 180 days prior to their application.

The UC Berkeley Labor Center estimates that the potential Bridge Plan eligible population in 2014 would be between 670,000 and 840,000.[ii]

[ii] Estimate is based on CalSIM data and assumes all Medi-Cal Managed Care plans offer Bridge plans. On an annual basis, an estimated enrollment of 860,000 -1,080,000 is projected.

Requirement for Guaranteed Issue. Bridge plan issuers would be required to comply with applicable laws, and in particular, the guaranteed issue requirements of Section 2702 of the Public Health Service Act. If the issuer demonstrates that the provider network serving both Medi-Cal Managed Care enrollees and Bridge enrollees is only sufficient to adequately handle this population, then the Bridge could be closed to non-Bridge eligible individuals. The following elements are proposed to address this requirement:

- The Department of Health Care Services would ensure there is a legally binding contractual obligation in place that would require a Medi-Cal Managed Care plan that offers a Bridge plan product to enroll Bridge plan eligible individuals.
- The Department of Managed Health Care would be authorized by the federal government to review capacity for Bridge plan issuers in regard to the Bridge plan product in the following manner: A health care service plan offering a Bridge Plan would be determined to have reached capacity by looking solely at the capacity of the Bridge plan product and not at the capacity of the health care service plan. Enrollment of individuals who are members of the MAGI household in which there are Medi-Cal or Medi-Cal/CHIP enrollees with that Bridge plan would not be considered new enrollment for purposes of determining capacity or state or federal provider network adequacy standards of the Bridge plan product.

Enrollment Issues & Data Exchange with Federal Government. The successful implementation of the Bridge Program would require close coordination with the Medi-Cal program, which is administered by the Department of Health Care Services (DHCS). The DHCS maintains a central database that includes current and historical data on individuals eligible for Medi-Cal and the plans in which they are enrolled. To administer the Bridge program, the CalHEERS system would query this system whenever an individual enrolls in coverage supported by an Advanced Premium Tax Credit. This query would determine whether there was a history of Medi-Cal enrollment and, if so, the plan in which the individual was enrolled. It would also be able to detect whether the new enrollee was a parent of a child enrolled in a Medi-Cal plan. In either of these cases, if the individuals' prior Medi-Cal plan is offered as a Bridge plan and the individual still resides in that plan's service area, the health plan choices presented to the new enrollee would include the Bridge plan among the available plan choices.

Contingent on federal approval, Bridge plan eligible individuals and family members would also have the option to enroll in a different Bridge plan if their primary care provider is included in the contracted network of the other Bridge plan and the eligible Bridge plan is either not offered in the service area or is not offered as a Bridge plan by the Exchange. In addition, Covered California would work with the DHCS to identify other pathways for notifying potential consumers who may be transitioning into Exchange-subsidized coverage. County eligibility workers and Covered California's

network of assisters would also be available to provide in-person help for Bridge eligible consumers.

CalHEERS would also be the mechanism for providing information on Bridge eligible individuals to the federal government in the same manner as other Exchange eligible individuals. Covered California would be able to track total Bridge plan enrollments by participating plan and provide an analysis of the impact that offering the Bridge plan has on the cost of coverage for eligible enrollees.

The Bridge proposal requires additional functions to be designed and developed within the CalHEERS. Once the program has been approved, Covered California will initiate development activities and determine the implementation schedule that balances the significant operational needs of the system.

Streamlining Approaches for Qualified Health Plan Certification for Medi-Cal Managed Care and Bridge Plans. Consistent with federal guidance, a Bridge plan product offered by a Medi-Cal Managed Care plan must meet all of the qualified health plan minimum requirements and be certified. The Bridge plan must also be determined to be in the interest of consumers. However, Covered California recognizes that Medi-Cal Managed Care plans are already engaged in intensive implementation efforts related to an array of new policy initiatives that are bringing new populations into managed care. Given the unique role that Medi-Cal Managed Care plans offer and the potential benefits to Covered California consumers, the following revisions to the qualified health plan solicitation process are recommended for Medi-Cal Managed Care plans that operate only in the non-commercial market:

- Allow Medi-Cal Managed Care plans to defer those elements of the solicitation that have not been applicable to a non-commercial health plan (e.g., waive their completing eValue8 elements in 2014).
- Accept state Medi-Cal quality and performance requirements as satisfying Exchange quality requirements during 2014.
- Coordinate with Department of Managed Health Care to streamline regulatory approval that may be required.

Additional recommended measures would only apply to Bridge plans in recognition of their unique timelines and schedule requirements.

- Covered California would develop a separate timeline for certifying Bridge qualified health plans for 2014 and later years.
- State law has been amended to allow Covered California to waive the requirement that Bridge plans offer all precious metal benefit tiers and catastrophic coverage, as well as the requirement to sell the same plans outside of Covered California. However, the federal requirement to offer both Silver and Gold precious metal benefit tiers would still apply.

- Allow Medi-Cal quality reporting features such as HEDIS measures to be used in lieu of other quality data requirements.

Evaluation. In the design of the Bridge Plan Demonstration Project, the evaluation component would be a critical element. In acknowledging the Bridge Program's policy tradeoffs, both for consumer benefits and disadvantages, the evaluation would establish an empirical, evidence-based approach for considering the merits of the proposal. Additional information about consumer preferences, behavior, and plan selection options would be needed to gauge the extent to which Bridge eligible consumers might be disadvantaged by having reduced purchasing power. To address this fundamental question, the Bridge Plan Demonstration Project would be evaluated across the following domains:

- Total Enrollment. Covered California would track enrollment in Bridge plans on a quarterly basis and the extent to which Bridge eligible enrollees choose the Bridge plan.
- Reduced Churn Between Medi-Cal and Exchange Plans. Data would be collected and analyzed to determine the extent to which Bridge plans reduce the level of churn among plans associated with the transition of consumers between Medi-Cal and Exchange based coverage.
- Greater Continuity of Care. Covered California, in consultation with the Department of Managed Health Care, would evaluate the extent to which Bridge plan enrollees are able to keep their existing provider relationships compared to enrollees who are not offered Bridge plans.
- Affordability. Covered California would evaluate the average premium and out-of-pocket costs of Bridge plan enrollees to determine the extent to which Bridge plans offer more affordable choices compared to former Medi-Cal eligible enrollees in the absence of a Bridge plan. The evaluation would also assess the extent to which Bridge plan eligible individuals receive smaller premium tax credits and whether this differential has an effect in choice of plans (i.e., whether they select a Bridge plan or a non-Bridge plan.
- Quality Measurement. The state's Medi-Cal Managed Care plans already provide a robust data set on various quality measures to the state's Department of Health Care Services. Covered California would collect and review quality data on a quarterly basis to determine quality metrics for Bridge plans compared to other offered plans.

The evaluation that will be incorporated into the design of the Bridge Plan Demonstration Project will provide a policy foundation to inform state and federal decision-makers on the options of extending or modifying the program.

If the Demonstration Project is successful, Covered California would pursue policy options that would institutionalize the Bridge program on an on-going basis. One approach for consideration would be a potential application in 2017 of a State

Innovation Waiver as authorized under the Affordable Care Act.

However, if it is determined that Demonstration Project has failed to achieve its objectives, no further new enrollment into Bridge plans would be permitted, and the plan would become a closed block of business. Specifically, the CalHEERS enrollment system would cease to offer the Bridge plan as an option for any new enrollment. Current enrollees would be allowed to renew their Bridge policies.

REFERENCE MATERIAL

Benjamin D. Sommers and Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*. Health Affairs. February 2011.

Laurel Lucia, Ken Jacobs, Miranda Dietz, Dave Graham-Squire, Nadereh Pourat, and Dylan H. Roby. *AFTER MILLIONS OF CALIFORNIANS GAIN HEALTH COVERAGE UNDER THE AFFORDABLE CARE ACT, WHO WILL REMAIN UNINSURED?* UC Berkeley Center for Labor Research and Education UCLA Center for Health Policy Research. September 2012. Available online: http://laborcenter.berkeley.edu/healthcare/aca_uninsured12.pdf

Miranda Dietz and Ken Jacobs. *Memorandum from UC Berkeley Labor Center to Covered California.* February 19, 2013. Available online: http://www.healthexchange.ca.gov/BoardMeetings/Documents/February26_2013/VI._UC_Berkeley_Bridge_Enrollment_Estimate_Memo.pdf.

Rick Curtis and Ed Neuschler, *Income Volatility Creates Uncertainty about the State Fiscal Impact of a Basic Health Program in California*: Using Data from a SIPP analysis by John Graves – with support from the California HealthCare Foundation. September 2, 2011.

Table 1: Sample Tax Credit for Purchase in the Individual Exchange				
Percent of FPL	**Annual Income**	**Unsubsidized Premium for Month**	**Tax Credit**	**Monthly Premium after Credit**
138%	$15,500	$379	$340	$40
150%	$16,700	$379	$324	$55
200%	$22,300	$379	$262	$117
250%	$28,000	$379	$192	$187
300%	$33,500	$379	$114	$265

Example based on a 40-year-old policyholder using 2014 projected incomes, assuming a "silver" plan covering 70 percent of expected medical utilization costs. Source: UC Berkeley Labor Center "Calculator."

Table 2: Reason enrollees leave Medi-Cal over the 12 months, enrollees under 138%, based on different time periods for income eligibility					
Eligibility for Med-Cal based on income from	**Income Increases, eligible for exchange subsidies**	**Income Increases, not eligible for exchange subsidies**	**Takeup ESI**	**Stay in Medi-Cal**	**Total**
Previous month	14.6%	1.8%	9.1%	74.5%	100%
Previous 6 months	13.1%	1.4%	8.8%	76.7%	100%
Previous 12 months	13.7%	1.4%	8.6%	76.4%	100%

Attachment 1

Price and Percentage Differential between the Second Lowest and Lowest Silver-Level Plans Rates, by Region (Rates shown are for a 40-year old enrollee)

Region by Number	Region by County Names	Second Lowest Silver-level Plan	Premium Rate	Lowest Silver-level Plan	Premium Rate	Differential
1	Alpine, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, Tuolumne	Blue Shield - EPO	$318	Anthem Blue Cross – PPO	$309	$9
2	Napa, Sonoma, Solano, Marin	Anthem Blue Cross – PPO	$343	Blue Shield – EPO	$338	$5
3	Sacramento, Placer, El Dorado, Yolo	Blue Shield – PPO	$333	Anthem Blue Cross – PPO	$332	$1
4	San Francisco	Anthem Blue Cross – EPO	$373	Chinese Community Health Plan – HMO	$325	$48
5	Contra Costa	Kaiser Permanente – HMO	$347	Blue Shield – PPO	$328	$19

Region by Number	Region by County Names	Second Lowest Silver-level Plan	Premium Rate	Lowest Silver-level Plan	Premium Rate	Differential
6	Alameda	Anthem Blue Cross – PPO	$357	Blue Shield – EPO	$317	$40
7	Santa Clara	Anthem Blue Cross – HMO	$340	Anthem Blue Cross – PPO	$336	$4
8	San Mateo	Kaiser Permanente – HMO	$383	Chinese Community Health Plan – HMO	$351	$32
9	Santa Cruz, Monterey, San Benito	Anthem Blue Cross – PPO	$382	Blue Shield – EPO	$335	$47
10	San Joaquin, Stanislaus, Merced, Mariposa, Tulare	Blue Shield - PPO	$322	Anthem Blue Cross – PPO	$295	$27
11	Fresno, Kings, Madera	Anthem Blue Cross – PPO	$288	Blue Shield – PPO	$284	$4
12	San Luis Obispo, Ventura, Santa Barbara	Anthem Blue Cross – PPO	$326	Blue Shield – PPO	$314	$12
13	Mono, Inyo, Imperial	Blue Shield – PPO	$396	Kaiser Permanente – HMO	$316	$80

Region by Number	Region by County Names	Second Lowest Silver-level Plan	Premium Rate	Lowest Silver-level Plan	Premium Rate	Differential
14	Kern	Anthem Blue Cross – PPO	$281	Blue Shield – PPO	$277	$4
15	Los Angeles (partial)	Blue Shield – PPO	$252	Health Net – HMO	$222	$30
16	Los Angeles (partial)	Anthem Blue Cross – HMO	$259	Health Net – HMO	$242	$17
17	San Bernardino, Riverside	Molina Healthcare – HMO	$259	Health Net – HMO	$246	$13
18	Orange	Anthem Blue Cross – HMO	$286	Health Net – HMO	$252	$34
19	San Diego	Anthem Blue Cross – EPO	$308	Health Net –HMO	$269	$39

Senate Bill No. 3

CHAPTER 5

An act to amend, repeal, and add Sections 100501 and 100503 of, and to add and repeal Sections 100504.5 and 100504.6 of, the Government Code, to amend, repeal, and add Section 1366.6 of, and to add and repeal Section 1399.864 of, the Health and Safety Code, to amend, repeal, and add Section 10112.3 of, and to add and repeal Section 10961 of, the Insurance Code, and to add and repeal Section 14005.70 of the Welfare and Institutions Code, relating to health care coverage.

[Approved by Governor July 11, 2013. Filed with Secretary of State July 11, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 3, Hernandez. Health care coverage: bridge plan.

Existing law, the federal Patient Protection and Affordable Care Act, requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the regulation of health insurers by the Department of Insurance.

Under existing law, carriers that sell any products outside the California Health Benefit Exchange (Exchange) are required to fairly and affirmatively offer, market, and sell all products made available to individuals or small employers in the Exchange to individuals or small employers, respectively, purchasing coverage outside the Exchange.

Existing law also requires carriers that participate in the Exchange to fairly and affirmatively offer, market, and sell in the Exchange at least one product within 5 levels of specified coverage.

This bill would exempt a bridge plan product, as defined, from that latter requirement.

This bill would, among other things, also require the Exchange to enter into contracts with and certify as a qualified health plan bridge plan products that meet specified requirements, including being a Medi-Cal managed care plan. The bill would also require the Exchange to make available bridge plan products to eligible individuals. The bill would authorize the Exchange, after consulting with stakeholders, to adopt regulations to implement those

provisions, and until January 1, 2016, exempt the adoption, amendment, or repeal of those regulations from the Administrative Procedure Act.

The bill would require the Exchange to annually prepare a specified written report on the implementation and performance of the Exchange functions during the preceding fiscal year, and to prepare, or contract for the preparation of, an evaluation of the bridge plan program using the first 3 years of experience with the program, as specified.

The bill would authorize a health care service plan or insurance carrier offering a bridge plan product in the Exchange to limit the products it offers in the Exchange to the bridge plan product, except as required by federal law. The bill would define "bridge plan product" as an individual health benefit plan offered by a licensed health care service plan or health insurer that contracts with the Exchange, as specified.

The bill would also require the State Department of Health Care Services to impose specified requirements in its contracts with a health care service plan or health insurer to provide Medi-Cal managed care coverage but would authorize the department to contract with the Exchange to delegate the implementation of those provisions.

The bill would require the Exchange to seek federal approval to allow specified individuals the option to enroll in a different bridge plan product if the individual's primary care provider is included in the contracted network of the different bridge plan product and either the bridge plan product for which the individual is eligible is not offered in that individual's service area or is not offered as a bridge plan product by the Exchange.

The bill would provide that its provisions would become inoperative on the October 1 that is 5 years after the date that federal approval of the bridge plan option occurs.

The people of the State of California do enact as follows:

SECTION 1. (a) It is the intent of the Legislature that the Exchange provide a more affordable coverage option for low-income individuals, improve continuity of care for individuals moving from Medi-Cal to the Exchange, and reduce the need for individuals previously enrolled in the Medi-Cal program to change health plans due to changes in their household income.

(b) In addition to other plan choices, it is the intent of the Legislature that the Exchange offer quality, affordable health plan choices that, to the extent possible, will be the lowest cost silver plan offered in the individual's geographic region through Medi-Cal managed care plans that bridge Medicaid coverage and private commercial health insurance for eligible lower income individuals.

(c) It is the intent of the Legislature that the Exchange encourage Medi-Cal managed care plans to seek to contract to offer bridge plan products.

SEC. 2. Section 100501 of the Government Code is amended to read:

100501. For purposes of this title, the following definitions shall apply:

(a) "Board" means the board described in subdivision (a) of Section 100500.

(b) "Bridge plan product" means an individual health benefit plan as defined in subdivision (f) of Section 1399.845 of the Health and Safety Code that is offered by a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or as defined in subdivision (a) of Section 10198.6 of the Insurance Code that is offered by a health insurer licensed under the Insurance Code that contracts with the Exchange pursuant to this title.

(c) "Carrier" means either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care.

(d) "Exchange" means the California Health Benefit Exchange established by Section 100500.

(e) "Federal act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(f) "Fund" means the California Health Trust Fund established by Section 100520.

(g) "Health plan" and "qualified health plan" have the same meanings as those terms are defined in Section 1301 of the federal act.

(h) "Healthy Families coverage" means coverage under the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(i) "Medi-Cal coverage" means coverage under the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

(j) "Modified adjusted gross income" shall have the same meaning as the term is used in Section 1401(d)(2)(B) (26 U.S.C. Sec. 36B) of the federal act.

(k) "Members of the modified adjusted gross income household" shall mean any individual who would be included in the calculation for modified adjusted gross income pursuant to Section 1401(a) (26 U.S.C. Sec. 36B(d)) of the federal act and as otherwise determined by the Exchange as permitted by the federal act and this title.

(*l*) "SHOP Program" means the Small Business Health Options Program established by subdivision (m) of Section 100502.

(m) "Supplemental coverage" means coverage through a specialized health care service plan contract, as defined in subdivision (o) of Section 1345 of the Health and Safety Code, or a specialized health insurance policy, as defined in Section 106 of the Insurance Code.

(n) This section shall become inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 3. Section 100501 is added to the Government Code, to read:

100501. For purposes of this title, the following definitions shall apply:

(a) "Board" means the board described in subdivision (a) of Section 100500.

(b) "Carrier" means either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care.

(c) "Exchange" means the California Health Benefit Exchange established by Section 100500.

(d) "Federal act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(e) "Fund" means the California Health Trust Fund established by Section 100520.

(f) "Health plan" and "qualified health plan" have the same meanings as those terms are defined in Section 1301 of the federal act.

(g) "SHOP Program" means the Small Business Health Options Program established by subdivision (m) of Section 100502.

(h) "Supplemental coverage" means coverage through a specialized health care service plan contract, as defined in subdivision (o) of Section 1345 of the Health and Safety Code, or a specialized health insurance policy, as defined in Section 106 of the Insurance Code.

(i) This section shall become operative only if Section 2 of the act that added this section becomes inoperative pursuant to subdivision (n) of that Section 2.

SEC. 4. Section 100503 of the Government Code is amended to read:

100503. In addition to meeting the minimum requirements of Section 1311 of the federal act, the board shall do all of the following:

(a) Determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with the state and local government entities administering other health care coverage programs, including the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and California counties, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage.

(b) Develop processes to coordinate with the county entities that administer eligibility for the Medi-Cal program and the entity that determines eligibility for the Healthy Families Program, including, but not limited to, processes for case transfer, referral, and enrollment in the Exchange of

individuals applying for assistance to those entities, if allowed or required by federal law.

(c) Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.

(d) Provide, in each region of the state, a choice of qualified health plans at each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act.

(e) Require, as a condition of participation in the Exchange, carriers to fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act. The board may require carriers to offer additional products within each of those five levels of coverage. This subdivision shall not apply to a carrier that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504.

(f) (1) Except as otherwise provided in this section and Section 100504.5, require, as a condition of participation in the Exchange, carriers that sell any products outside the Exchange to do both of the following:

(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Managed Risk Medical Insurance Board and carriers for enrolled Healthy Families beneficiaries or contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and carriers for enrolled Medi-Cal beneficiaries. "Product" also does not include a bridge plan product offered pursuant to Section 100504.5.

(3) Except as required by Section 1301(a)(1)(C)(ii) of the federal act, a carrier offering a bridge plan product in the Exchange may limit the products it offers in the Exchange solely to a bridge plan product contract.

(g) Determine when an enrollee's coverage commences and the extent and scope of coverage.

(h) Provide for the processing of applications and the enrollment and disenrollment of enrollees.

(i) Determine and approve cost-sharing provisions for qualified health plans.

(j) Establish uniform billing and payment policies for qualified health plans offered in the Exchange to ensure consistent enrollment and disenrollment activities for individuals enrolled in the Exchange.

(k) Undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency.

(*l*) Select and set performance standards and compensation for navigators selected under subdivision (*l*) of Section 100502.

(m) Employ necessary staff.

(1) The board shall hire a chief fiscal officer, a chief operations officer, a director for the SHOP Exchange, a director of Health Plan Contracting, a chief technology and information officer, a general counsel, and other key executive positions, as determined by the board, who shall be exempt from civil service.

(2) (A) The board shall set the salaries for the exempt positions described in paragraph (1) and subdivision (i) of Section 100500 in amounts that are reasonably necessary to attract and retain individuals of superior qualifications. The salaries shall be published by the board in the board's annual budget. The board's annual budget shall be posted on the Internet Web site of the Exchange. To determine the compensation for these positions, the board shall cause to be conducted, through the use of independent outside advisors, salary surveys of both of the following:

(i) Other state and federal health insurance exchanges that are most comparable to the Exchange.

(ii) Other relevant labor pools.

(B) The salaries established by the board under subparagraph (A) shall not exceed the highest comparable salary for a position of that type, as determined by the surveys conducted pursuant to subparagraph (A).

(C) The Department of Human Resources shall review the methodology used in the surveys conducted pursuant to subparagraph (A).

(3) The positions described in paragraph (1) and subdivision (i) of Section 100500 shall not be subject to otherwise applicable provisions of the Government Code or the Public Contract Code and, for those purposes, the Exchange shall not be considered a state agency or public entity.

(n) Assess a charge on the qualified health plans offered by carriers that is reasonable and necessary to support the development, operations, and prudent cash management of the Exchange. This charge shall not affect the

requirement under Section 1301 of the federal act that carriers charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange.

(o) Authorize expenditures, as necessary, from the California Health Trust Fund to pay program expenses to administer the Exchange.

(p) Keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the United States Secretary of Health and Human Services a report concerning that accounting. Commencing January 1, 2016, the board shall conduct an annual audit.

(q) (1) Annually prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, including, at a minimum, the manner in which funds were expended and the progress toward, and the achievement of, the requirements of this title. The report shall also include data provided by health care service plans and health insurers offering bridge plan products regarding the extent of health care provider and health facility overlap in their Medi-Cal networks as compared to the health care provider and health facility networks contracting with the plan or insurer in their bridge plan contracts. This report shall be transmitted to the Legislature and the Governor and shall be made available to the public on the Internet Web site of the Exchange. A report made to the Legislature pursuant to this subdivision shall be submitted pursuant to Section 9795.

(2) The Exchange shall prepare, or contract for the preparation of, an evaluation of the bridge plan program using the first three years of experience with the program. The evaluation shall be provided to the health policy and fiscal committees of the Legislature in the fourth year following federal approval of the bridge plan option. The evaluation shall include, but not be limited to, all of the following:

(A) The number of individuals eligible to participate in the bridge plan program each year by category of eligibility.

(B) The number of eligible individuals who elect a bridge plan option each year by category of eligibility.

(C) The average length of time, by region and statewide, that individuals remain in the bridge plan option each year by category of eligibility.

(D) The regions of the state with a bridge plan option, and the carriers in each region that offer a bridge plan, by year.

(E) The premium difference each year, by region, between the bridge plan and the first and second lowest cost plan for individuals in the Exchange who are not eligible for the bridge plan.

(F) The effect of the bridge plan on the premium subsidy amount for bridge plan eligible individuals each year by each region.

(G) Based on a survey of individuals enrolled in the bridge plan:

(i) Whether individuals enrolling in the bridge plan product are able to keep their existing health care providers.

(ii) Whether individuals would want to retain their bridge plan product, buy a different Exchange product, or decline to purchase health insurance if there was no bridge plan product available. The Exchange may include

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Memorandum

To: Covered California
From: Miranda Dietz and Ken Jacobs
Re: Eligibility estimates for Medi-Cal Managed Care Bridge Plans, April-Dec 2014
Date: February 19, 2013

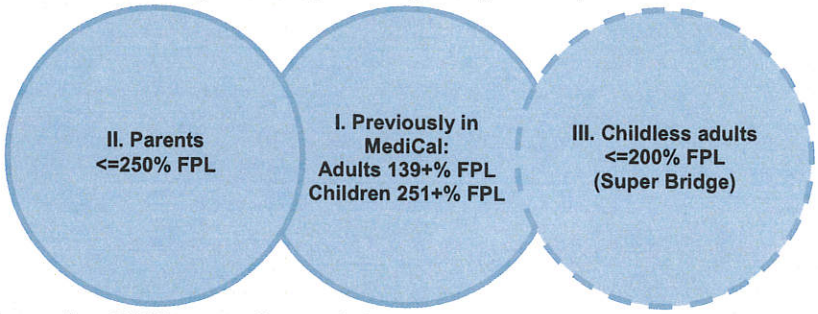
Covered California is considering offering MediCal Managed Care Bridge Plans to encourage continuity of care and provide low cost options on the Exchange for low income Californians. Starting in April 2014, these plans would be offered to:

I. Individuals who were previously in MediCal but whose incomes have increased such that they are no longer eligible for MediCal;
II. Parents in families with children enrolled in MediCal/CHIP;[1]

and, under the so-called "Super Bridge" option,

III. Childless adults with income at or below 200% FPL.[2]

MediCal Bridge and Super Bridge Eligible Populations



From April to December 2014, we estimate 670,000—840,000 Californians would enroll in Covered California and be eligible for a Bridge Plan, and an additional 240,000—420,000 would be eligible under the Super Bridge option, for a total of 920,000—1,310,000. To make our estimate, we predict the number of people in each of the three groups over the course of the nine months in which the Bridge is available in 2014, and then subtract the overlap, i.e. making sure that a parent whose income goes from 100% FPL to 150% FPL is only counted once, even though she would fall into both group I. and group II. This estimate includes those who are predicted to enroll in the Exchange in 2014 and would ever be *eligible* to choose a Bridge Plan in the course 2014, but does not estimate the number of people expected to *enroll* in a Bridge Plan instead of choosing another Qualified Health Plan. Because this population involves transitions from one income group to another, the estimate is for over the course of 2014, not a point in time. As such, the estimate includes people who would only be eligible for the Bridge option for a short amount of time.

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[1] We assume that the existence of a new plan in April would count as a qualifying event, so that those already enrolled in Covered California who would be eligible for the Bridge Plan could switch when the plan becomes available in April 2014.
[2] In the Super Bridge income range, children would be in Medi-Cal and parents would be in the family member of a child in MediCal/CHIP eligibility category

This analysis relies on Exchange enrollment estimates from CalSIM,[3] but does not include estimates of the number of additional people who might enroll in the Exchange due to lower premiums. Analysis of the Basic Health Plan, which assumes even lower premiums than those anticipated for Bridge Plans, provides an upper bound point-in-time estimate of 60,000-120,000 *extra* enrollees in the Exchange that this low-cost offer may attract.

I. Previously in MediCal

Analysis based on the Survey on Income and Program Participation and CalSIM suggests that, of likely MediCal enrollees at a point in time, 14.6% of them have income increases to 139-400% FPL over the course of 12 months and would be eligible for subsidies in the Exchange.[4] Assuming that this income volatility occurs at a constant rate, April – December would yield ¾ as much volatility, or 11.0% with income increases to 139-400% FPL over the course of the nine months. For this analysis we assume the vast majority of those who lose eligibility for Medi-Cal due to income increases will enroll in the Exchange; the actual take up rate will depend in part on the strength of outreach to this population. Accounting for the different threshold for adults (138% FPL) and children (250% FPL) but assuming similar rates of income volatility, and accounting for volatility among those who join MediCal throughout the nine months, we estimate **570,000 – 630,000** people who were in MediCal at some point April – December 2014 will transition to a higher income and become eligible for the Exchange with subsidies, including the Bridge Plan.

II. Parents at or below 250% FPL

Using CalSIM we estimate that in 2014 at a point in time, 160,000 – 260,000 parents will have incomes at or below 250% FPL and be enrolled in the Exchange with subsidies.[5] Monthly churn for the Exchange has been estimated at 5-6%. Applying this rate of churn results in **230,000 – 400,000** parents who are ever at or below 250% FPL and enrolled in the Exchange with subsidies in April – December 2014. These parents are expected to enroll in the Exchange and would be eligible for the Bridge Plan.

Next we estimate how much overlap there is among this population of parents in the Exchange with incomes at or below 250% FPL and people who were previously in MediCal (groups II and I). Using 2014 CalSIM estimates of the number of parents in MediCal and the estimate that 12.5% of those starting under 139% FPL have income fluctuations to 139-250% FPL over the course of a full year, we predict that **120,000 – 140,000** parents will transition from MediCal to 139-250% FPL from April – December 2014 and will thus be part of both groups.

III. Childless Adults 139-200% FPL

Using CalSIM we estimate 220,000 – 340,000 childless adults will have incomes at or below 200% FPL and be enrolled in the Exchange with subsidies in 2014 at a point in time.[6] Applying the monthly churn estimate of 5-6% to this population, we expect that **320,000 – 520,000** childless adults would ever be within the 139-200% income range and enrolled in the Exchange with subsidies in April – December 2014. These childless adults are expected to enroll in the Exchange and would be eligible for the Super Bridge Plan.

Next we estimate how much overlap there is among this population of childless adults with incomes at or below 200% FPL and people who were previously in MediCal (groups III and I). In 2014 using CalSIM estimates of the number of childless adults in MediCal and the estimate that 10.1% of those starting under 139% FPL have income fluctuations to 139-200% FPL over the course of a full year, we predict that **80,000 – 100,000** childless adults will transition from MediCal to 139-200% FPL from April – December 2014 and will thus be part of both groups.

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[3] UC Berkeley–UCLA California Simulation of Insurance Markets (CalSIM) model, version 1.8

[4] All estimates are for subsidy eligible individuals. An additional 1.8% have income increases above 400% FPL; if we include these people as eligible for the Bridge Plan, total estimates increase by about 100,000.

[5] This includes roughly 10,000 – 30,000 Legal Permanent Residents of less than five years with incomes at or below 138% FPL, and assumes that their children will be eligible for state-only MediCal and they will be eligible for the Bridge Plan.

[6] This includes roughly 20,000 – 40,000 Legal Permanent Residents of less than five years with incomes at or below 138% FPL, and assumes that they will be eligible only under the Super Bridge Plan.

Table: Ever enrolled in the Exchange or transitioning out of MediCal and eligible for the Bridge or Super Bridge, April – December 2014

	Base / Low Estimate	Enhanced / High Estimate
I. Previously in MediCal	570,000	630,000
II. Parents <=250% FPL	230,000	400,000
Overlap of I. & II.	(120,000)	(140,000)
BRIDGE ESTIMATE	**680,000**	**890,000**
III. Childless Adults <=200% FPL	320,000	520,000
Overlap of I. & III.	(80,000)	(100,000)
ADDITIONAL SUPER BRIDGE	**240,000**	**420,000**
TOTAL WITH SUPER BRIDGE	**920,000**	**1,310,000**